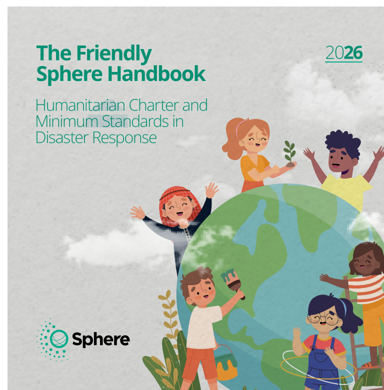
The Friendly Sphere Handbook

2026

Humanitarian Charter and Minimum Standards in Disaster Response

ABOUT THIS GUIDE



The Friendly Sphere Handbook is a shortened and illustrated version of the 2018 Sphere Handbook.

This is the first Friendly Sphere Handbook to be published in English.

It is based on the 2020 Friendly Sphere Handbook prepared by Sphere's focal point in Bolivia.

We hope that you find this shortened version of the Sphere Handbook useful in your work.

This guide was prepared in partnership with Community World Service Asia (CWSA), Sphere's Regional Partner for Asia

*PLEASE NOTE: If you plan to use any of the numerical indicators in this guide, please refer first to the full **2018 Sphere Handbook** so that you can read any accompanying guidance about contextualising them to your situation.*

Published in 2026
Based on 2018 Sphere Handbook

ABOUT SPHERE

Sphere is about upholding the dignity and rights of crisis-affected people through principled, accountable and quality humanitarian action.

Sphere was started in 1997 by impassioned aid workers who wanted to improve the quality of emergency response. With this goal in mind, they framed the Humanitarian Charter and identified a set of Minimum Standards to be applied contextually in all humanitarian crises.

Initially developed by non-governmental organisations and the International Red Cross and Red Crescent Movement, Sphere resources are primary reference tools for local, national and international NGOs, UN agencies, governments, donors, the private sector, volunteers, and many others.

Today, Sphere is a global network bringing together and empowering practitioners to improve and sustain the quality and accountability of humanitarian assistance. Sphere hosts the Humanitarian Standards Partnership (HSP), the Minimum Economic Recovery Standards (MERS) and is joint copyright holder of the Core Humanitarian Standard.

Sphere's flagship publication, the Sphere Handbook, is one of the most widely known and internationally recognised set of humanitarian principles and minimum standards.

I. WHAT IS THE SPHERE HANDBOOK?

"The Humanitarian Charter and Minimum Standards in Disaster Response" – better known as the Sphere Handbook - is a universal tool for humanitarian responders to save lives and meet the needs of people affected by disaster or conflict.

The Sphere philosophy is based on two core beliefs:

- People affected by disaster or conflict have the right to life with dignity and, therefore, the right to assistance; and
- All possible steps should be taken to alleviate human suffering arising out of disaster or conflict.

The Sphere Handbook puts these beliefs into practice.

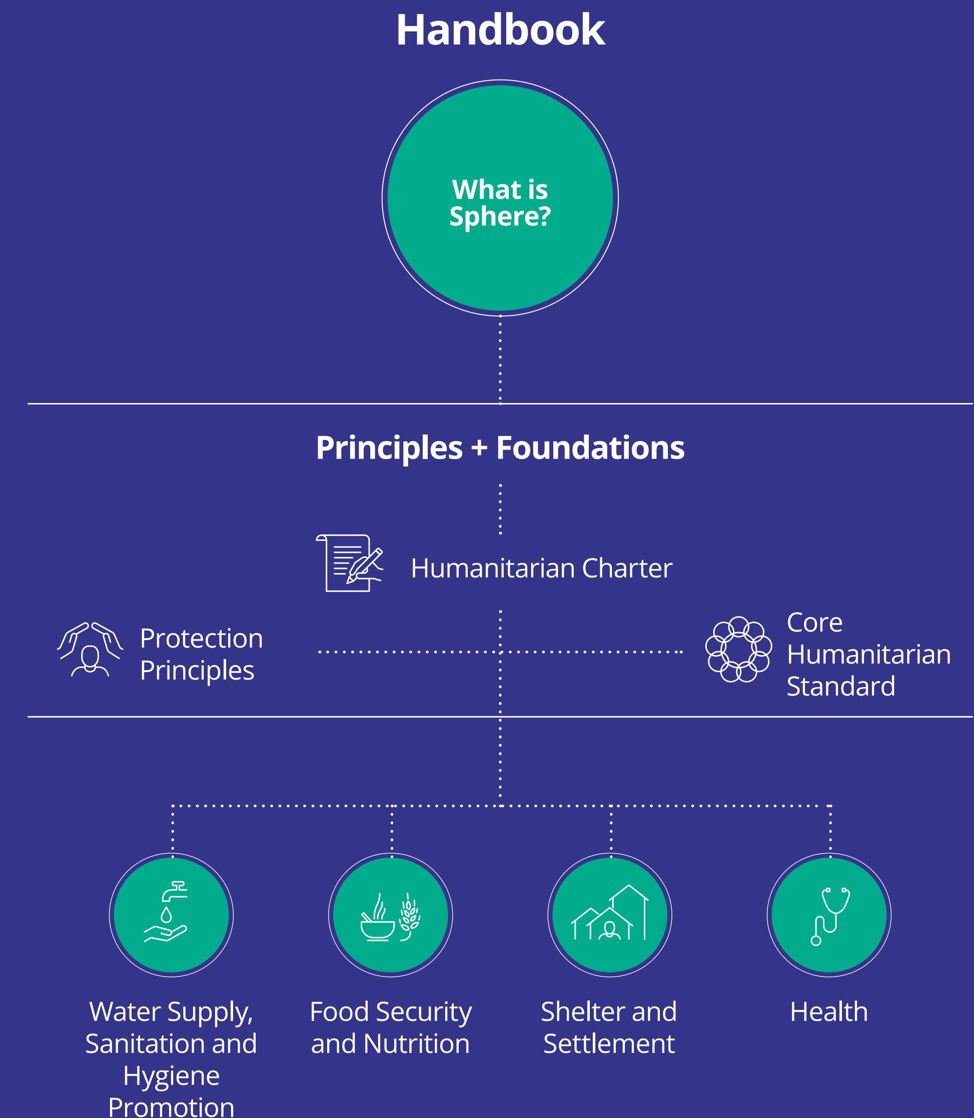
It has two interdependent parts, consisting of:

- Three foundation chapters; and
- Four technical chapters

STRUCTURE OF THE SPHERE HANDBOOK

The Sphere Handbook is designed for anyone who provides humanitarian assistance and is useful in preparedness, planning, disaster and conflict risk reduction, early recovery; as well as development and pandemic contexts.

It is also a valuable advocacy tool.



MAKING BEST USE OF MINIMUM STANDARDS

The Sphere Handbook promotes a coherent approach to humanitarian response and reflects universal human rights. The standards describe what must be in place as a minimum for people to survive and recover from crisis with dignity.

The Handbook does not provide a definitive "how-to" guide for humanitarian response, as each situation is different.

In some situations, it may be difficult to meet the Sphere minimum standards. When the minimum cannot be met, it is important to understand and explain why it cannot be met.

In other situations, the minimum standards might sometimes exceed the living conditions of the host community. This needs to be managed sensitively to avoid tension between displaced people and host communities.

The standards share a common structure:

The Standards have been developed to be universal, but actions and indicators must be contextualised to ensure that each response is appropriate to the situation.

APPLICATION OF STANDARDS THROUGHOUT THE RESPONSE

During each phase of the programme (or project) cycle it is essential to ensure participation and consultation with women, men, girls and boys of all ages and backgrounds, especially those who are marginalized within the specific context.

The standards can be applied in the first days of a response, for months or even years, especially given the growing number of protracted crises.

The Sphere Handbook and its Minimum Standards are useful for:

- Assessment and analysis; of the situation and context, to help identify immediate needs and prioritise activities, to coordinate across organisations.
- Implementation/delivery; of humanitarian assistance, to meet minimum quality standards. If standards cannot be met, understand why and explain the gaps as well as what needs to change.
- Strategy development, programme planning and design; of multisectoral response, through collaboration between different actors.
- Monitoring, evaluation, accountability and learning (MEAL); of humanitarian operations, to adjust to changing contexts. All of the Minimum Standards have indicators that can be monitored to measure progress towards meeting standards.

ESSENTIAL CONSIDERATIONS IN APPLYING THE MINIMUM STANDARDS

Every effort should be made to ensure that people have access to appropriate humanitarian assistance; taking into account the differences between the following populations:

Boys and girls

Timely and child-sensitive humanitarian assistance can improve the safety and well-being. This addresses life-threatening risks, such as malnutrition, separation from families, child trafficking, recruitment into armed groups, psychosocial distress, violence and physical or sexual abuse.

Older people

They can be key actors in humanitarian response. They bring knowledge and experience of coping strategies and act as caregivers, resource managers, coordinators and income generators.

Gender

"Gender" refers to the socially constructed differences between women and men throughout their life cycle. Gender equity is fundamental to human rights and the basis of the Humanitarian Charter.

Survivors and persons at risk of gender-based violence (GBV)

Crisis situations will exacerbate many forms of gender-based violence, including partner violence, child marriage and sexual violence. New forms may emerge due to the crisis itself, including trafficking and sexual exploitation.

People living with HIV/AIDS

Humanitarian crises can cause life-threatening service disruptions, especially if protective measures are not implemented.

Mengtal health and psychosocial support

This is essential for alleviating suffering, enabling people to make good decisions, cope better to crisis and to participate more in community life. Existing faith communities have great potential to contribute to any humanitarian response.

In the early days of an acute emergency, humanitarian assistance patterns are likely to be different from how aid is delivered over several months or years.

- In addition to the community themselves, the first responders to a crisis are often local or national actors, including individuals, local authorities, volunteers, civil society, religious, charity and welfare associations, Red Cross/Red Crescent Societies, or NGOs.
- Multilateral and international agencies may also respond, especially if requested by the authorities.
- Armed forces may also be involved in emergency response. In some cases, they may also be part of the conflict.
- Assistance can be provided in-kind, as cash assistance, through the provision of services or by providing technical expertise.

The Sphere Handbook is designed for use in all environments, including:

Towns and cities (or Urban) where people use cash to pay rent, buy food and access healthcare.

Camps and other communal settings (or Informal) such as collective centres or settlements, are home to millions of displaced persons.

When humanitarian organisations respond in the same area as national or international armed forces it is important to know the mandates, operating procedures, capabilities and limitations of each.

Integrating environmental concerns, risk reduction and climate considerations into humanitarian response reflects people's dependence on the environment. The relationship between environment and humanitarian action is twofold:

i. **Crises often arise from poor environmental management or environmental emergencies, such as chemical or technical incidents.**

ii. **Humanitarian operations affect the environment.** They may further damage the environment or may improve current environmental conditions. At a minimum, humanitarian response should consider the environment as part of a "do no harm" approach and ideally seek to protect and restore nature.

Climate change increases risk and vulnerability to natural hazards; as storms, droughts and floods affect livelihoods, health and food production systems.

There are many positive benefits to be gained from addressing environmental issues during the early stages of a crisis. Effective humanitarian response must assess environmental risk along with broader assessments to develop quality programming.

Environmentally concerned actions, including nature-based solutions, are now essential to good humanitarian operations and improves the overall quality and effectiveness.

PARTNER STANDARDS

The four life-saving technical chapters of the Sphere Handbook do not cover all aspects of humanitarian response. The Humanitarian Standards Partnership (HSP) is a group of humanitarian standard-setting initiatives that work together to improve the quality and accountability of humanitarian action.

Standards and Guidelines for Emergency Livestock Interventions (LEGS)

Helps identify the most appropriate livestock interventions in emergency situations;

Minimum Standards for the Protection of Children in Humanitarian Action (CPMS):

Alliance for the Protection of Children in Humanitarian Action;

Minimum Standards for Education: Preparedness, Response and Recovery:

Inter-Agency Network for Education in Emergencies (INEE);

Minimum Standards for Economic Recovery (MERS):

Small Business Education and Promotion Network (SEEP)

Minimum Market Analysis Standards (MMA):

Cash Learning Partnership (CaLP).

Humanitarian Inclusion Standards for Older Adults and People with Disabilities:

HelpAge International and CBM Global

Minimum Standards for Camp Management:

Camp Coordination and Camp Management Cluster

Standards for Supporting Crop-related Livelihoods in Emergencies:

SEADS

Like Sphere, these partner standards are also rights-based and are developed through an extensive consultation process with the humanitarian community. You can find out more about them here: *www.hspstandards.org*

II. THE HUMANITARIAN CHARTER

Provides the ethical and legal context for the Protection Principles, the Core Humanitarian Standard and the Minimum Standards presented in the Handbook.

It is a statement of legal rights and obligations; as well as shared beliefs.

OUR BELIEFS

Every person affected by disaster or conflict has the **right to receive protection and assistance** in order to ensure the basic conditions for life with dignity.

OUR ROLE

We recognise that it is primarily through their own efforts and through the support of local communities and institutions that the **basic needs of people affected by disaster or conflict are met.**

We call on state and non-state actors to respect the impartial, independent and non-partisan role of humanitarian organisations, allowing timely and consistent access to affected populations.

COMMON PRINCIPLES, RIGHTS AND RESPONSIBILITIES

We provide services as humanitarian organisations, based on humanitarian principles and the humanitarian imperative, recognising that all people have a right to receive humanitarian assistance; to protection and security; and to life with dignity.

International Humanitarian Law (IHL) treaties primarily consist of the Geneva Conventions and their Additional Protocols, which outline rules for the conduct of armed conflict and protection of those not participating in hostilities. These treaties, along with customary international law, form the foundation of IHL.

The right to life with dignity is reflected in the provisions of IHL. The right to life entails a duty to preserve life where it is threatened.

The right to receive humanitarian assistance is a necessary element of the right to life with dignity. This includes the right to an adequate standard of living, including: food, water, clothing, shelter and healthcare, which are expressly mandated by IHL.

The right to protection and security is rooted in IHL, as well as other intergovernmental organisations mandates and in the sovereign responsibility of States to protect all within their jurisdiction. This includes the protection of refugees and internally displaced persons.

OUR COMMITMENT

We offer our services with the conviction that the **affected population is at the centre of humanitarian action** and that their active participation is essential.

In collaboration with affected communities and authorities, our goal is to minimise any negative impact of humanitarian action on the local community or the environment.

We will act in accordance with the humanitarian principles set out in this Charter and in the **Code of Conduct** of the Red Cross and Red Crescent Movement and non-governmental organizations (NGOs).

We invite all parties to adopt the Core Humanitarian Standard and the Sphere Minimum Standards, **as accepted norms**. By adhering to the Core Humanitarian Standard and the Sphere Minimum Standards, we recognise that our primary responsibility must be to those we seek to assist.

III. PROTECTION PRINCIPLES

Protection refers to the security, dignity and rights of people affected by disasters or armed conflicts. It is central to all humanitarian action, because it helps people avoid or recover from violence, coercion and deprivation of liberty. However, when the State cannot or does not want to act to protect people, all humanitarian actors have a role to play by getting collectively involved to achieve meaningful protection results for the affected population.

UNDERSTANDING PROTECTION

Protection is: "...all activities aimed at obtaining full respect for the rights of the individual in accordance with the letter and spirit of relevant bodies of law; i.e. the Universal Declaration of Human Rights, international humanitarian law and international refugee law." (Inter-Agency Standing Committee (IASC).

Protection work requires engaging with affected people during all phases of a humanitarian response to understand risks, threats, capabilities and how people take action and decisions to protect themselves.

THE FOUR PROTECTION PRINCIPLES

1. Prevent: Enhance the safety, dignity and rights of people, and avoid exposing them to harm.

2. Respond: Ensure people's access to assistance according to their needs and without discrimination.

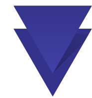
3. Remedy: Assist people to recover from the physical and psychological effects of threatened or actual violence, coercion or deliberate deprivation.

4. Claim: Help people claim their rights.

These principles may be interdependent and carried out at the same time. The principles promote the right to life with dignity through three ways or types of activities:

Integrate protection risks, activities and related information;

Incorporate specific protection objectives; and



Promote specialised protection activities.

Mainstreaming protection means incorporating specific protection objectives into sectoral responses, such as nutrition or shelter.

Doing so encourages different actors to work individually and together as part of a multisectoral humanitarian response. It therefore makes protection a central consideration.

Advocacy links the four protection principles and the three types of activities. When threats to the affected population arise from deliberate decisions, actions or policies, humanitarian or human rights organizations may advocate for changes in those behaviours or policies.

IV. THE CORE HUMANITARIAN STANDARD

The Core Humanitarian Standard (CHS) on Quality and Accountability (CHS) sets out nine commitments by aid actors to crisis-affected people to ensure that assistance respects their rights, dignity and promotes their primary role in finding solutions to their situation.

The CHS promotes equitable and collaborative relations between people and communities and those working to support them. It aims to address power imbalances. It is relevant and applicable for all those who individually or collectively work to support people and communities. It can be used as a framework to:

- Enable people and communities to hold those who support them to account.
- Improve the quality and accountability of organisations and their work.
- Assess and verify organisations' performance and demonstrate their learning journey towards meeting the CHS commitments.
- Promote collective efforts to ensure quality and accountability

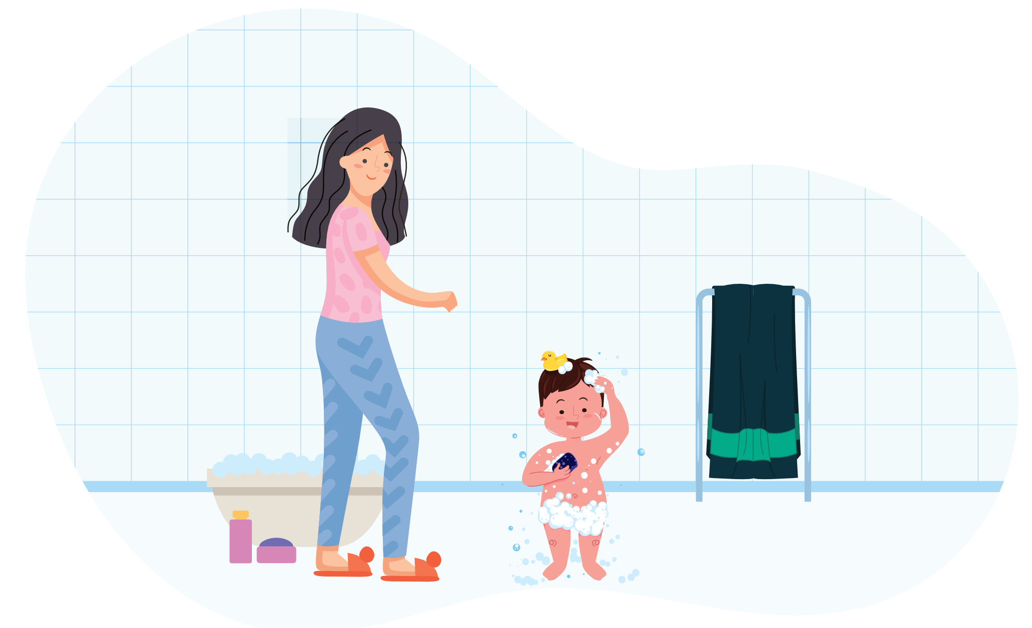
The nine commitments describe what people and communities in situations of crisis and vulnerability can expect from those that support them.

V. WATER SUPPLY, SANITATION AND HYGIENE PROMOTION

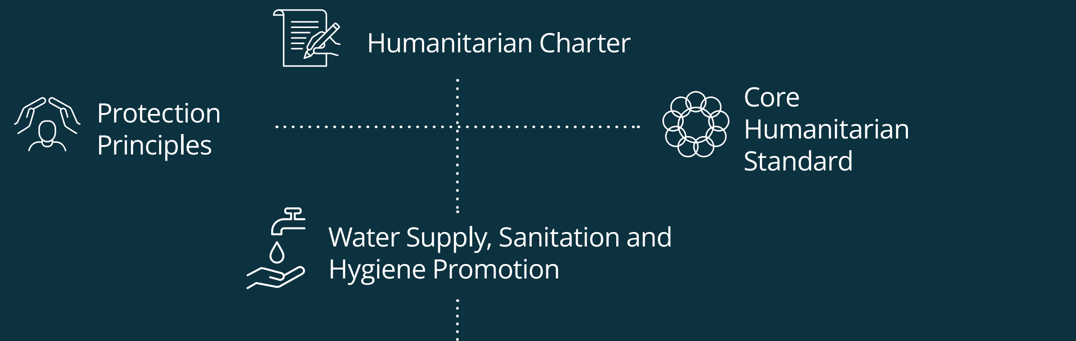
ESSENTIAL CONCEPTS

Everyone has the right to water and sanitation.

Everyone must have physical access to sufficient, affordable, and safe water for personal and household use as well as for cooking and cleaning.



Adequate provision of safe water and sanitation facilities are essential to: sustain life and health, prevent death from dehydration, reduce the risk of disease, and allow proper use of water for cooking, personal hygiene, and domestic needs.



Hygiene promotion	Water supply	Excreta management	Vector control	Solid Waste management	WASH in disease outbreaks and healthcare settings
Standard 1.1: Hygiene promotion	**Standard 2.1:** Access and water quantity	**Standard 3.1:** Environment free from human excreta	**Standard 4.1:** Vector control at settlement level	**Standard 5.1:** Environment free from solid waste	**Standard 6:** WASH in healthcare settings
Standard 1.2: Identification, access and use of hygiene items	**Standard 2.2:** Water quality	**Standard 3.2:** Access to and use of toilets	**Standard 4.2:** Household and personal actions to control vectors	**Standard 5.2:** Household and personal actions to safely manage solid waste	
Standard 1.3: Menstrual hygiene management and incontinence		**Standard 3.3:** Management and maintenance of excreta collection, transport, disposal and treatment		**Standard 5.3:** Solid waste management systems at community level	

Appendix 1: *Water Supply, Sanitation and Hygiene Promotion initial needs assessment checklist*
Appendix 2: *The F diagram: Faecal-oral transmission of diarrhoeal diseases*
Appendix 3: *Minimum water quantities: survival figures and quantifying water needs*
Appendix 4: *Minimum numbers of toilets: community, public places and institutions*
Appendix 5: *Water- and sanitation-related diseases*
Appendix 6: *Household water treatment and storage decision tree*

1. WATER, SANITATION AND HYGIENE (WASH) PROGRAMMES

The aim of the WASH programme is to promote good personal and environmental hygiene; to protect health, welfare and safety; and to ensure life with dignity.

Participation of individuals and communities in programme design is essential, based on their capacity and will.

WASH interventions are planned, designed and implemented in a way that improves the long-term community objectives.

WASH interventions should minimise adverse environmental impacts and support environmental sustainability.

Ensure that any WASH intervention undertaken by an organisation is integrated with all other WASH interventions affecting a community; Integrate WASH programming with at-risk groups such as: pregnant and lactating women, infants, girls and children, the elderly, people with disabilities, people with HIV/AIDS, etc. Ensure that WASH programmes have sufficient staff with capacity, relevant experience and skills.

2. HYGIENE

The promotion of hygiene and community involvement are critical to a successful WASH response. It is not just about providing messages, information and distribution of hygiene kits; it involves community engagement and mobilisation, the promotion of positive health-seeking behaviour, and the facilitation of community and individual action leading to a more effective outcome.

- **Hygiene promotion standard 1.1:** People are aware of key public health risks related to water, sanitation and hygiene, and can adopt individual, household and community measures to reduce them.
- **Hygiene promotion standard 1.2:** Identification, access to and use of hygiene items: Appropriate items to support hygiene, health, dignity and well-being are available and used by the affected people.

It is important to assess behaviours and existing practices in the affected population that relate to key public health risks.

People have access to hygiene items suitable for their priority needs, such as: 2 containers of water per household for drinking and domestic use (1 for collection, 1 for storage); 250 grams of soap per person per month, hand-washing articles and 200 grams of soap per person per month for washing clothes.

Hygiene promotion standard 1.3: Menstrual hygiene management and incontinence: Women and girls of menstruating age, and males and females.

Understand cultural and religious beliefs, social norms and myths about menstrual hygiene and incontinence treatment. Women and girls can access and use culturally appropriate menstrual hygiene materials; i.e. reusable sanitary pads (minimum 6 units/year) or disposable sanitary towels (15 units/month); underwear (6 units/year) and extra soap (250 grams/month).

3. WATER SUPPLY

Water is essential for life, health protection and human dignity. In extreme situations, the available water may not be sufficient to meet basic needs. Supplying a survival level of safe drinking water is essential. The priority is to provide an adequate quantity of water, even if it is of intermediate quality.

Water supply standard 2.1: Access and water quantity: People have equitable and affordable access to a sufficient quantity of.

Identify the most appropriate water sources and quantify the water requirements of the affected population, according to their customs.

Consult stakeholders on the location, design and implementation of water distribution points and ensure an appropriate drainage point for the water.

The recommended minimum amount of water per person per day for drinking, household activity and personal hygiene is 15 litres per person per day.

Consumption of water (drink and food)	2.5-3.0 litres per day	Depends on climate and individual physiology
Hygiene practices	2.0-6.0 litres per day	Depends on social and cultural norms
Basic cooking	3.0-6.0 litres per day	Depends on type of food and social and cultural norms
Total basic water requirements	7.5-15.0 litres per day	

The maximum number of people using a water-based facility is:

- 250 people per tap (with a flow rate of 7.5 litres per minute).
- 500 people per hand pump (with a flow rate of 17.0 litres per minute).
- 400 people per open hand well (with a flow rate of 12.5 litres per minute).
- 100 people per laundry facility.
- 50 people per shower installation.

The distance to a water distribution point must be less than 500 meters (1641 feet).

The waiting time for a person at a water distribution point should be less than 30 minutes.

Water supply standard 2.2: Water quality: In households, water must be safely stored in clean and covered containers at all times; and each container must carry a tap.

4. EXCRETA MANAGEMENT

Human excrement is defined as the waste material that is discharged from the body, especially faeces and urine, but also includes menstrual waste. An environment free of human excreta (including surface and groundwater sources) is essential for dignity, safety, health and the well-being of people

For this Handbook, the word “toilet” means any installation or device that immediately contains excreta, such as: a bucket; a urinal; a pit latrine; or a flush toilet.

These excreta management standards cover the entire excreta chain, from initial containment of excreta to final treatment.

Excreta management standard 3.2: People have adequate, appropriate and acceptable toilets to allow rapid, safe and secure access at all times.

Determine the most appropriate technical excreta management options; Take into account local topography, soil conditions and groundwater and surface water context (including seasonal variations). Consult all interested parties on the location, design and implementation of shared or common toilets.

Excreta management standard 3.1: All excreta is safely contained on-site to avoid contamination of the natural, living, learning, working and communal environments.

All excreta containment facilities are at a distance of at least 30 meters from the containment to the water source. The bottom of pits should be at least 1.5 meters above the groundwater table.

None of the surface or ground water sources are contaminated by effluent from excreta containment facilities.

Excreta management standard 3.3: Excreta management facilities, infrastructure and systems are safely managed and maintained to ensure service provision and minimum impact on the surrounding environment.

Work with local authorities responsible for the management of excreta, to ensure that collection, transport, treatment and disposal systems are integrated into local systems. Facilities, infrastructure and excreta management systems are managed and maintained in a secure manner, to ensure service provision.

Clean toilets regularly.

Define the most appropriate structures and systems for short- and long-term management of toilets (i.e, pits, vaults, septic tanks, soakage pits). Establish clear and accountable roles and responsibilities to manage future operation and maintenance.

Remember, excreta is also a potential energy resource i.e. biogas, combustible bricks, compost.

5. VECTOR CONTROL

A vector is an agent carrying disease. Vectors create a pathway from the source of a disease to people. Vector-borne diseases are a major cause of disease and death in many humanitarian settings.

Some insects - even if they are not disease vectors - can also cause painful bites. They may be symptoms of solid waste management problems, drainage deficiencies in site selection or wider safety and security issues.

It is important to assess the potential risk of vector-borne disease. Ensure that the components of solid waste management, excreta management, drainage and water supply are designed and implemented to reduce or eliminate the risk of problem vectors.

Vector control standard 4.1: People live in an environment where vector breeding and feeding sites are targeted to reduce the risks of vector-related problems.

Design and implement vector control programmes, based on a risk assessment of the main vector in settlements; together with the people affected and the host communities.

Vector control standard 4.2: All affected people have the knowledge and means to protect themselves and their families from vectors that can cause a significant risk to health or well-being.

Assess current vector-elimination behaviours and practices in the home, both of the affected population and of host communities, as part of an overall hygiene promotion programme.

6. SOLID WASTE MANAGEMENT

Solid waste management is the process of handling waste: including organic and inorganic, domestic, institutional and communal, hazardous (including medical waste) and non-hazardous. Inadequate management of solid waste poses a risk to public health. This includes the growth of flies and rodents in solid waste and the contamination of surface and groundwater by solid waste.

Unmanaged solid waste can present a threat of injury or disease, especially for girls and boys who play in rubble. It can also block drainage channels, increasing the risk of flooding, and can create stagnant and contaminated surface water, which can lead to environmental health problems.

It is important to involve those affected and the host community, in planning solid waste systems. All sites should have complete, appropriate and practical solid waste systems.

Consider the waste management needs of host communities as part of the whole system, reflecting the additional waste generated.

Vector control standard 4.1: People live in an environment where vector breeding and feeding sites are targeted to reduce the risks of vector-related problems.

Vector control standard 4.2: All affected people have the knowledge and means to protect themselves and their families from vectors that can cause a significant risk to health or well-being.

All households have access to collection points; located at least 49.2 feet (15 metres) from their homes.

Provide initially one container of 100 litres per 40 households and, in the longer term, one container per 10 households.

All solid waste is safely reused, recycled, composted, disposed of or treated. Health facilities collect and dispose of hazardous waste properly, all the time.

Ensure that medical or hospital waste does not hurt, or harm affected people, host communities, or the environment.

7. WASH IN DISEASE OUTBREAKS

Community engagement remains a key component of outbreak response in order to prevent the spread of disease. Existing community perceptions and beliefs can support or hinder a response, so it is important to understand and address them. The recent outbreaks of Ebola, cholera and COVID-19 have highlighted the importance of adequate preparedness, strong coordination, technical capacity and joint responses between WASH and health sectors.

Communities have access to information, essential items and services designed to prevent and respond to communicable diseases.

Carry out a rapid public health risk and WASH assessment to determine which areas and populations are at greatest risk (including by age, gender and vulnerability).

The affected population has access to hygiene items appropriate to their priority needs. People affected understand the importance and use of Oral Rehydration Salts (ORS), which are prepared in 1 litre of drinking water, with 1/2 small tablespoon of salt (3.5 grams) and four large spoons of sugar (40 grams).

Standard 6: WASH in healthcare settings: All healthcare settings maintain minimum WASH infection prevention and control standards, including in disease outbreaks.

Hospitalised patients have 40 to 60 litres of water per person per day; and outpatients have 5 litres per consultation.

Health facilities properly dispose of hazardous waste and prepare and store food safely.

8. WASH AND NUTRITION-FOCUSED RESPONSES

Malnutrition includes low weight for age, dangerously thin for height, too short for age (stunted) and deficient in micronutrients.

The determinants of malnutrition are complex and nutritional status depends on a wide range of factors, such as food security; inappropriate care practices; poor access to health care; and an unhealthy environment, including adequate access to water, sanitation and hygiene. Malnutrition is often associated with recurrent episodes of diarrhoea. This forms “vicious circle” of recurrent disease and further deterioration of nutritional status.

- The risks of infectious diseases, due to poor WASH conditions, that negatively affect nutritional status, are reduced by working with the community.

Map key areas of concern, such as poor nutritional status and poor WASH status. Affected households acquire and strengthen the habit of washing their hands with soap and water; prepare and store food for children in a safe manner; and know and apply at least one home water treatment method.

- Staff and patients entering and leaving from the nutrition centres, have access to safely managed WASH facilities and services and hygiene supplies.

Ensure that supplementary feeding centres, outpatient treatment centres and health centres running inpatient nutrition programmes have adequate WASH facilities. Undertake specific hygiene promotion programmes in the dedicated nutrition centres, or health centres or clinics, which report on the collaboration between the Nutrition Programmes and the WASH Programmes.

VI. FOOD SECURITY AND NUTRITION

ESSENTIAL CONCEPTS

Everyone has the right to be free from hunger and to have adequate food.

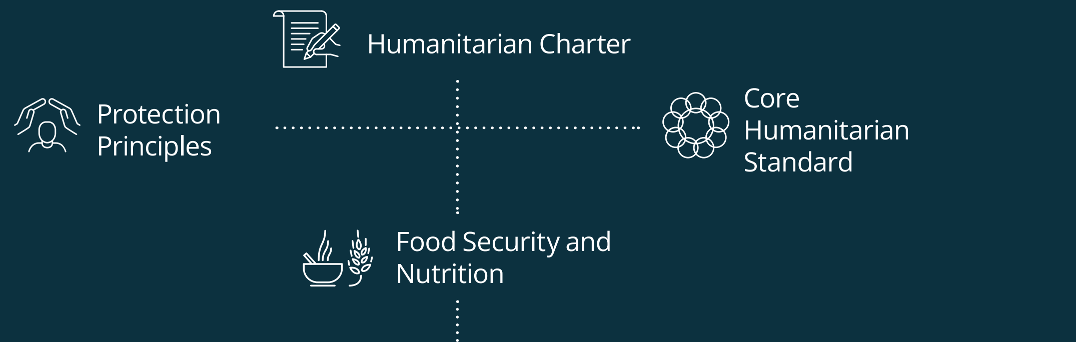
International law recognises the right to physical and economic access to adequate food at all times.

In disasters, access to food and maintaining adequate nutritional status are determinants of people’s survival. People affected by a disaster are often already chronically malnourished. Malnutrition is a serious public health problem and a major cause of death, either directly or indirectly.

Food security and nutrition are closely related to the other Minimum Standards and require complementary responses with all other humanitarian sectors. For example, food usually needs safe water to be washed, and hygiene ensured. The treatment and prevention of malnutrition are related to health. Cooking fuel and energy sources can have a significant impact on shelter, protection and health. Food security and nutrition interventions must be designed and planned in coordination and collaboration with other sectors to have effective responses.

Recognising the different roles of women in family nutrition is key to improving household food security. Women often play a very important role in planning and preparing food for their homes.

The nutrition of infants and young children should be a priority given their vulnerability. Preventing malnutrition is as important as treating acute malnutrition.



Assessments	Management of malnutrition	Micronutrient deficiencies	Infant and young child feeding	Food security	Food assistance	Livelihoods
Standard 1.1: Food security assessment	**Standard 2.1:** Moderate acute malnutrition	**Standard 3.1:** Micronutrient deficiencies	**Standard 4.1:** Policy guidance and coordination	**Standard 5.1:** General food security	**Standard 6.1:** General nutrition requirements	**Standard 7.1:** Primary production
Standard 1.2: Nutrition assessment	**Standard 2.2:** Severe acute malnutrition	**Standard 3.2:** Access to and use of toilets	**Standard 4.2:** Multi-sectoral support to infant and young child feeding in emergencies	**Standard 5.2:** Household and personal actions to safely manage solid waste	**Standard 6.2:** Food quality, appropriateness and acceptability	**Standard 7.2:** Income and employment
Standard 1.3: Menstrual hygiene management and incontinence		**Standard 3.3:** Management and maintenance of excreta collection, transport, disposal and treatment			**Standard 6.3:** Targeting, distribution and delivery	
					STANDARD 6.4: Food use	

Appendix 1: *Food security and livelihoods assessment checklist*
Appendix 2: *Seed security assessment checklist*
Appendix 3: *Nutrition assessment checklist*
Appendix 4: *Measuring acute malnutrition*
Appendix 5: *Measures of the public health significance of micronutrient deficiencies*
Appendix 6: *Nutritional requirements*

1. FOOD SECURITY AND NUTRITIONAL ASSESSMENT

Timely nutrition assessments are useful in establishing the magnitude of a nutritional crisis and the underlying factors. The process helps identify the populations, subgroups or individuals most affected and at greatest risk in a given area.

Nutrition assessments provide an estimate of the needs of the affected population; and identify priority nutrition actions to be implemented. These are useful in planning, implementing and monitoring nutrition programs.

Food security and nutrition assessments standard 1.1: Food security assessment: Where people are at risk of food insecurity, assessments are conducted to determine the degree and extent of food insecurity, identify those most affected and define the most appropriate response.

Conduct at least one comprehensive food security needs assessment during the first week of an emergency response and analyse available cooking methods, including the type of stove and fuel used.

Conduct a market assessment to contribute to the response analysis.

Nutrition assessments use accepted methods to identify the type and degree of malnutrition and the appropriate response for people at higher risk.

Anthropometric surveys are used to examine physical proportions of the body and provide an estimate of the rates of chronic and acute malnutrition.

2. PREVENTION AND TREATMENT OF MALNUTRITION

Malnutrition can be chronic or acute. Chronic malnutrition can generally not be reversed or treated. Acute malnutrition, which could be triggered by a crisis, can be prevented and corrected with appropriate nutritional interventions. The long-term health consequences of malnutrition include restricted physical and cognitive development. A multisectoral response is therefore essential to address all causes and their interactions.

Management of malnutrition standard 2.1: Moderate acute malnutrition is prevented and managed.

Include the components of hospital care, outpatient care, remission and population mobilisation in the management of severe acute malnutrition.

Investigate and act on the causes of non-compliance and non-response or increased deaths, including the reasons for any death.

Monitor with special emphasis, protection, support and promotion of breastfeeding, complementary feeding and hygiene promotion.

Micronutrient deficiencies standard 3: Micronutrient deficiencies are corrected.

Collect information on the pre-crisis situation to identify the most common micronutrient deficiencies. Train health personnel on how to identify and treat micronutrient deficiencies.
Examples include vitamin A (to control measles) and zinc (to control diarrhoea).

3. INFANT AND YOUNG CHILD FEEDING

Adequate and timely support for feeding infants and young children in emergency situations saves lives and protects the nutrition, health and development of girls and boys. Inadequate infant and young child feeding practices undermine maternal health and increase the vulnerability of mothers, girls and boys to malnutrition, disease and death. Crises increase risk. Girls and younger boys are the most vulnerable.

Priority actions to protect and support the nutritional needs of breastfed and non-breastfed infants and young children aged 0-23 months include:

Breastfeeding protection and support; management of artificial feeding for infants without the possibility to breastfeed; appropriate and safe complementary feeding. The support of pregnant and lactating women is essential for the well-being of their children.

“Exclusive breastfeeding” means that a baby does not receive any liquids other than breast milk, and does not contain solids, except for micronutrient supplements or necessary medicines.

Breastfeeding ensures optimal brain development and continues to protect the health of infants and older children, especially in contexts where WASH conditions are insufficient. Breastfeeding also protects maternal health by delaying menstruation and protecting against breast cancer.

Infant and young child feeding standard 4.1: Policy guidance and coordination: Policy guidance and coordination ensure safe, timely and appropriate infant and young child feeding.

Support strong, harmonised and timel communication on actions and interventions to protect and support the nutritional needs of breastfed and non-breastfed infants and young children aged 0-23 months, at all levels of response.

Designate a national agency to receive donations that replace breast milk, such as liquid dairy products, bottles and teats; within 72 hours of the onset of the emergency.

Infant and young child feeding standard 4.2: Multi-sectoral support to infant and young child feeding in emergencies: Mothers and caregivers of infants and young children have access to timely and appropriate feeding support that minimises risks, is culturally sensitive and optimises nutrition, health and survival outcomes.

Give priority to pregnant and lactating women, so that they have access to cash or voucher food transfers and other support interventions.

4. FOOD SECURITY

Food security exists when all people, at all times, have physical and economic access to sufficient, safe and nutritious food [and the means to cook that food] to meet their dietary needs and food preferences, for an active and healthy life. (World Food Summit, 1996).

Food security interventions in humanitarian crises should aim to meet short-term needs and reduce the need for people to adopt potentially harmful coping strategies.

5. FOOD ASSISTANCE

Food assistance aims to ensure the consumption of sufficient, safe and nutritious food during and after a humanitarian crisis.

It can also be used to prevent the adoption of negative coping mechanisms.

Food assistance requires good supply chain management and logistical capabilities.

The administration of any cash delivery system should be sound and responsible.

Food assistance standard 6.1: General nutrition requirements: The basic nutritional needs of the affected people, including the most vulnerable, are met.

The affected population reaches the minimum threshold of consumption of reliable food, such as: 2,100 Kcal per day, for adults.

Use levels of access to food quantity and quality to determine whether the nutritional status is stable.

Protect, promote and support the population's access to appropriate nutritious food and nutritional support for particular population groups such as: young children; older people; pregnant and lactating women; households with members with chronic diseases, including people living with HIV/AIDS and tuberculosis; and persons with disabilities, in particular persons with feeding difficulties.

Food assistance standard 6.2: Food quality, appropriateness and acceptability: The food items provided are of appropriate quality, are acceptable and can be used efficiently and effectively.

Select food at the point of purchase or donation that meets host government national standards and other internationally accepted quality standards.

Transport and store food in appropriate conditions. Use best practices in storage management, with systematic food quality controls.

Food losses must be less than 0.2% of the total weight.

The affected population reports that food provided is of appropriate quality, meets local preferences and the mechanism for receiving food was appropriate.

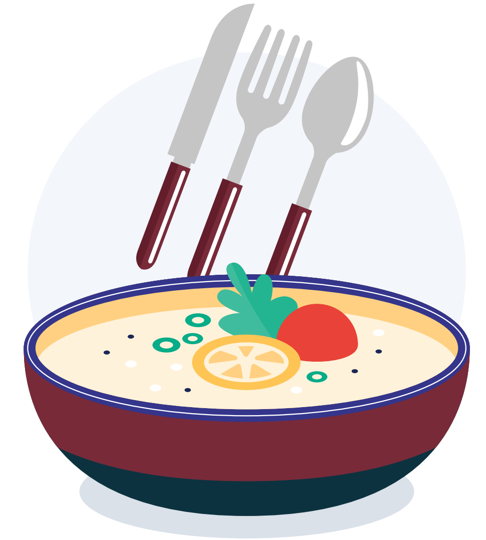
Food is also reported to be easy to prepare and store.

Food assistance standard 6.3: Targeting, distribution and delivery: Food assistance targeting and distribution is responsive, timely, transparent and safe.

Identify and target recipients of food assistance, based on needs and consultations with appropriate stakeholders.

Design efficient and equitable food or direct cash/voucher delivery mechanisms, in consultation with partner organisations, local groups and target groups.

Provide recipients with advance details of the distribution plan and schedule, the quality and quantity of the food ration or cash/voucher value and what is intended to be covered.



Food assistance standard 6.4: Food use: Storage, preparation and consumption of food is safe and appropriate at both household and community levels.

Ensure that families have safe access to adequate cooking utensils, fuel, low-consumption stoves, drinking water and hygiene materials.

For people who cannot prepare food or who cannot feed themselves, be sure to liaise with caregivers who can prepare the right foods and administer the food when needed.

6. LIVELIHOODS

People's ability to protect their livelihoods will depend on their vulnerability to the crisis.

Understanding vulnerabilities before, during and after a crisis facilitates the provision of appropriate assistance and identifies ways in which communities can rehabilitate and improve their livelihoods.

All livelihood interventions should aim to use and/or support local markets. (Cross-reference with the Minimum Economic Recovery Standards (MERS) Handbook).

Livelihoods standard 7.1: Primary production mechanisms receive protection and support.

Provide production inputs/assets to farmers. Make sure they are locally acceptable, conform to appropriate quality norms and are on time for best seasonal use.

Train farmers and producers in better management practices and involve men and women of the affected and host population in planning actions to ensure meaningful participation by men and women.

Livelihoods standard 7.2: Income and employment: Women and men receive equal access to appropriate income-earning opportunities where income generation and employment are feasible livelihood strategies.

Base decisions regarding income-earning activities and types of payment (cash, coupon, food or a combination) on consultation with men and women.

The target population diversifies its income-generating activities and thus increases their net income during a defined time period.

VII. SHELTER AND SETTLEMENT STANDARDS

ESSENTIAL CONCEPTS

The right to adequate housing includes the right to live in a safe, peaceful and dignified place.

Adequate housing contains both responsibilities and rights, including: protection against forced evictions, arbitrary destruction and demolition of their home and the right to housing, land and property restitution; the right to choose a residence, place of residence and freedom of movement; security of tenure; participation in decision-making on housing at national and community level.

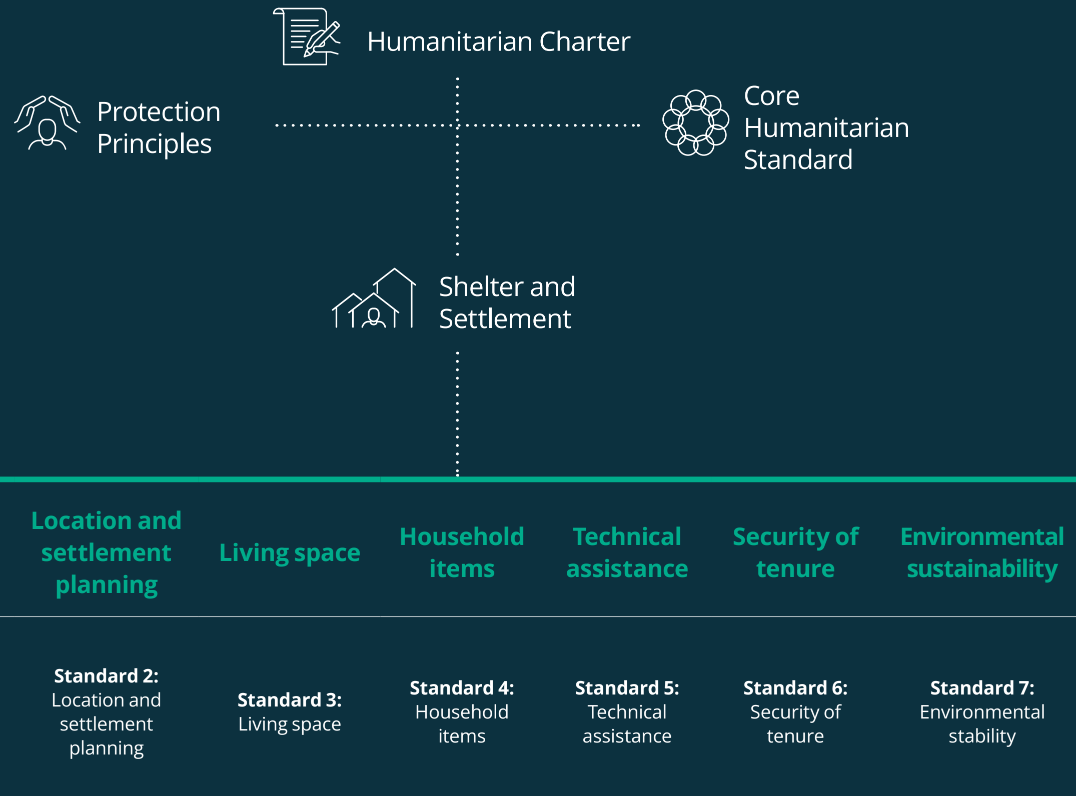
Shelter is a critical determinant for survival in the initial stages of a crisis, as it provides security, privacy and protection to individuals. Adequate housing supports living conditions that improve health and prevent the spread of disease.

Beyond survival, shelter contributes to human dignity, provides stability, contributes to psychosocial well-being, provides a place to work and offers the possibility of connecting with community life and forming a family. Recovery and reconstruction start from the very first day of a crisis. At a minimum, work towards adequate physical living space in a safe place with an appropriate and secure level of tenure rights. Shelter support is not limited to the delivery of tools, materials or the construction of a shelter.

Helping people in urban areas can be complicated due to increased spatial density, infrastructure needs, government regulations and diversity of social behaviours.

Shelter: Household living space, including necessary items to support daily activities (see Living Space Standard).

Settlement: Location of the community where people live (see Site Location and Planning Standard).



Appendix 1: *Shelter and settlement assessment checklist*
Appendix 2: *Description of settlement scenarios*
Appendix 3: *Additional characteristics of settlement scenarios*
Appendix 4: *Assistance options*
Appendix 5: *Implementation options*
Appendix 6: *Potential assistance and implementation options connected to settlement scenarios (online)*

1. STRATEGIES, ASSISTANCE OPTIONS AND IMPLEMENTATION METHODS

Shelter assistance, initially providing life-saving support, offers shelter options for the duration of the humanitarian response, and should contribute to permanent recovery.

The goal is for people affected by the crisis to return to adequate housing and normality as soon as possible. Good shelter approaches should continue to improve living conditions, moving towards long-term solutions of reconstruction, resettlement and reintegration.

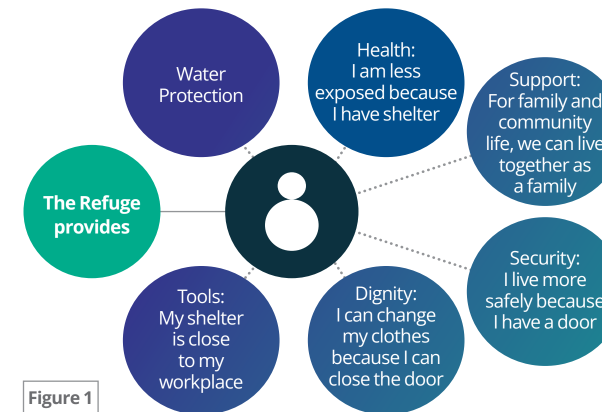


Figure 1

Shelter and settlement standard 1: Planning: Shelter and settlement interventions are well planned and coordinated to contribute to the safety and well-being of affected people and promote recovery.

Understand the context of pre- and post-crisis shelter and settlement and consider location, type of housing, tenure, market and legal frameworks.

Accommodation options must meet or exceed the agreed safe building standards.

2. ENVIRONMENT FOR SHELTER AND SETTLEMENT

Security of tenure usually refers to protection against forced evictions; but, in a humanitarian response, the scope of ownership is wider given the challenges of housing and settlement in a changing environment.

Linkages with other sectors, through a multisectoral settlement approach, are critical to considering the terms of access to essential services, income-generating activities and social networks.

Shelter and settlement standard 6: Security of tenure: The affected population has security of tenure in its shelter and settlement options.

Understand the legal framework and the reality on the ground: Support protection against eviction. Include security of tenure, as an indicator of vulnerability, in monitoring and evaluation.

Shelter and settlement standard 7: Environmental sustainability: Shelter and settlement assistance minimises any negative programme impact on the natural environment.

Use materials and techniques appropriate to the context (familiar, acceptable, affordable) and ensure proper disposal of all non-recyclable materials or waste that could have a negative effect on the natural environment.

Establish, restore and promote safe, reliable and affordable sustainable energy systems.

Figure 1: Some of the functions of shelters in emergencies, the shelter program supports families in achieving a dignified life

3. LIVING SPACE

Immediately after a crisis, it is often difficult to think of shelter beyond the physical protection of a roof and four walls. However, the concept of humanitarian shelter goes beyond the structure of a building. Adequate space, physical conditions and quality of construction are important and contribute greatly to providing security, privacy, protection and dignity.

Shelter and settlement standard 2: Location and settlement planning: Shelters and settlements are located in safe and secure areas, offering adequate space and access to essential services and livelihoods.

Involve the affected population and all major stakeholders at all stages of selection, site planning and settlement; to ensure access essential services and livelihood opportunities.

For camp-type settlements, the minimum usable area is 148 square feet (45 square metres) per person, intended for: roads and footpaths, external cooking areas or communal cooking areas, education and recreation areas, healthcare facilities, sanitation, firebreaks, administration, water storage, site drainage, religious facilities, food distribution areas, markets, storage and limited kitchen gardens for individual households.

Shelter and settlement standard 3: Living space: People have access to living spaces that are safe and adequate, enabling essential household and livelihoods activities to be undertaken with dignity.

The covered living space ensures privacy and has a minimum surface of 37.7 square feet (3.5 square metres) per person in tropical or warm climates, excluding cooking facilities.

Covered living space of 48.4–59.2 square feet (4.5-5.5 square metres) per person in cold climates or urban environments, including kitchen and bathroom and/or sanitation facilities.

The internal height from floor to ceiling is at least 6.6 square feet (2 metres) to the highest point (8.5 feet, or 2.6 metres, in hot climates).

Girls and boys have a safe space to play. The affected populations have sufficient and appropriate quality mosquito nets; as well as at least one blanket, one mattress and bed linen per person, to ensure safe, healthy and private sleeping.

In cold climates additional blankets and thermal insulation are required.

Shelter and settlement standard 5: Technical assistance : People have access to appropriate technical assistance in a timely manner.

Accommodation is durable, healthy, accessible and appropriate to their culture and context.

Shelters are repaired, modernised, updated or maintained; using safe construction techniques, quality materials and technical expertise in their construction.

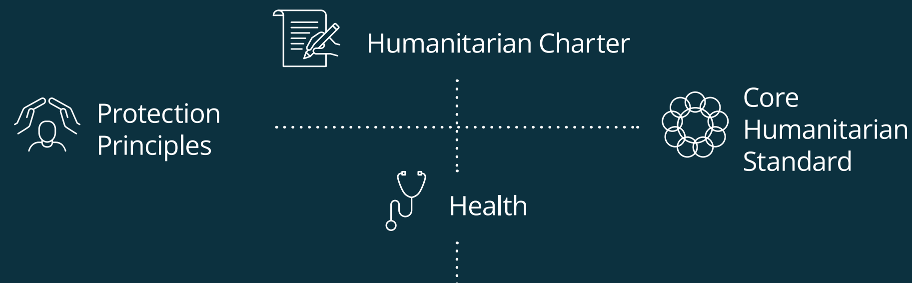
VIII. HEALTH

ESSENTIAL CONCEPTS

Everyone has the right to healthcare.

This right includes water and sanitation, safe food, healthy environmental conditions, gender equality and health-related information and education. Health services should be provided without discrimination and should be accessible, acceptable, affordable and of good quality.

Urban crises require a different approach to health responses, given the greater density of people, services, policies and behaviours.



Health systems	Essential Healthcare						
	Communicable diseases	Child health	Sexual and reproductive health	Injury and trauma care	Mental health	Non-communicable diseases	Palliative care
Standard 1.1: Health service delivery	**Standard 2.1.1:** Prevention	**Standard 2.2.1:** Childhood vaccine-preventable diseases	**Standard 2.3.1:** Reproductive, maternal and newborn healthcare	**Standard 2.4:** Injury and trauma care	**Standard 2.5:** Mental health care	**Standard 2.6:** Care of non-communicable disease	**Standard 2.7:** Palliative care
Standard 1.2: Health workforce	**Standard 2.1.2:** Surveillance and outbreak detection and early response	**Standard 2.2.2:** Management of newborn and childhood illness	**Standard 2.3.2:** Sexual violence and clinical management of rape				
Standard 1.3: Essential medicines and Medical devices	**Standard 2.1.3:** Diagnosis and case management		**Standard 2.3.3:** HIV				
Standard 1.4: Health financing	**Standard 2.1.4:** Outbreak preparedness and response						
Standard 1.5: Health information							

Appendix 1: *Health assessment checklist*
Appendix 2: *Sample weekly surveillance reporting forms*
Appendix 3: *Formulas for calculating key health indicators*
Appendix 4: *Assistance options*

1. HEALTH SYSTEMS

A well-functioning health system can ensure that the health care delivered in a crisis meets all needs.

It helps to avoid excess mortality and morbidity from vaccine-preventable diseases or easily treatable conditions; even during a large-scale health crisis, such as an Ebola outbreak or a pandemic like COVID-19.

Health systems standard 1.1: Health service delivery : People have access to integrated quality healthcare that is safe, effective and patient-centred.

Have one healthcare facility per 10,000 people, and one district or rural hospital per 250,000 people.

Provide medical care that guarantees patients' rights to dignity, privacy, confidentiality, security and informed consent.

Handling and burying dead people in a safe, dignified and culturally appropriate manner, taking into account people's faith practices.

Health systems standard 1.2: Healthcare workforce: People have access to healthcare workers with adequate skills at all levels of healthcare.

Recruit sufficient staff, ensuring a mix of skills and ethnic and gender proportions where possible; Integrate local staff.

Have one to two community health workers per 1,000 inhabitants and 23 skilled birth attendant personnel (doctors, nurses, midwives) per 10,000 inhabitants.

Health systems standard 1.3: Essential medicines and medical devices: People have access to essential medicines and medical devices that are safe, effective and of assured quality.

Ensure the availability of safe and essential medicines and medical devices; through an effective drug or donation management system.

Health systems standard 1.4: Health financing: People have access to free priority healthcare for the duration of the crisis.

Requiring payment for services during an emergency impedes access and may prevent people from seeking healthcare.

Health systems standard 1.5: Health information: Healthcare is guided by evidence through the collection, analysis and use of relevant public health data.

Early warning surveillance reports received from 90% of the health centres, each week.

- People have access to health coordinated across levels of health services, agencies and sectors; to achieve maximum impact.

The World Health Organization and health sector partners have a health plan that defines health needs and an agreed response strategy.

2. ESSENTIAL HEALTHCARE

- People have access to healthcare, to address the main causes of excess mortality and morbidity.

Identify barriers to access to prioritised health services; and practical solutions to address them.

A humanitarian crisis, whether it is a disaster, conflict, famine or pandemic (COVID-19), increases morbidity and mortality from communicable diseases. The movement of people to crowded camps or shelters means that diseases such as diarrhoea and measles spread easily.

- **Communicable diseases standard 2.1.1:** Prevention: People have access to healthcare and information to prevent communicable diseases.

Implement cross-sectoral measures to prevent communicable diseases for populations at risk and a coordinated vaccination strategy for those affected. Girls and boys from 6 months to 15 years old should receive the measles vaccine. Girls and boys aged 12 months old should have received 3 doses of DPT (diphtheria, whooping cough and tetanus).

- **Communicable diseases standard 2.1.2:** Surveillance, outbreak detection and early response: Surveillance and reporting systems provide early outbreak detection and early response.

Implement a context-specific disease early warning system and response network, based on surveillance reports received from 90% of health facilities each week.

- **Communicable diseases standard 2.1.3:** Diagnosis and case management: People have access to effective diagnosis and treatment for infectious diseases that contribute most significantly to morbidity and mortality.

Develop and disseminate health education messages and provide timely medical care.

- **Communicable diseases standard 2.1.4:** Outbreak preparedness and response: Outbreaks are adequately prepared for and controlled in a timely and effective manner.

Create and disseminate a multisectoral plan for responding to outbreaks, epidemics and pandemics (COVID-19), coordinating logistics and outbreak-specific response capacity; for example, by successful vaccination.

3. CHILD HEALTH

During crises, children are highly vulnerable to infection, disease and rising morbidity and mortality rates. Child health interventions should alleviate suffering and focus on survival, growth and development. Programmes should address the main causes of morbidity and mortality, such as acute respiratory infections, diarrhoea, measles, malaria, malnutrition and neonatal conditions.

- **Child health standard 2.2.1:** Childhood vaccine-preventable diseases: Children aged six months to 15 years have immunity against disease and access to routine Expanded Programme on Immunization (EPI) services during crises.

Estimate measles vaccination coverage for girls and boys aged 6 months to 15 years, at the beginning of the humanitarian response, to determine the risk of outbreaks.

When measles vaccination coverage is less than 90% or unknown, conduct a massive measles vaccination campaign for girls and boys from six months to fifteen years of age. Include vitamin administration to girls and boys 6-59 months of age.

Ensure that girls and boys vaccinated between 6 and 9 months of age receive another dose of measles vaccine at 9 months.

Establish a system for displaced persons to ensure that at least 95 per cent of new arrivals in a camp or community, between six months and 15 years old, are vaccinated against measles.

- **Child health standard 2.2.2:** Management of newborn and childhood illness: Children have access to priority healthcare that addresses the major causes of newborn and childhood morbidity and mortality.

Establish appropriate management for the treatment of diphtheria and pertussis in situations where the risk of outbreak is high.

All girls and boys are vaccinated in a timely manner and at the appropriate doses.

4. SEXUAL AND REPRODUCTIVE HEALTH

All people, including those living in humanitarian settings, have the right to sexual and reproductive health (SRH).

To exercise this right, affected populations must have access to the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH), and transition to comprehensive SRH information and services as soon as possible.

Service providers work in collaboration and complement each other, to ensure that people have access to SRH and MISP as soon as possible.

Ensure that community members are aware of the available MISP and take specific measures to reach out to girls, boys and adolescents; disabled persons and any others who may have difficulty accessing this information.

Support referral mechanisms and implement measures to reduce the risk of sexual and gender-based violence (SGBV).

Health centres and clinics have access to at least four contraceptive methods (pills, injectables, IUDs, implants) between three and six months after the onset of the crisis.

Sexual and reproductive health standard 2.3.1: Reproductive, maternal and newborn healthcare: People have access to healthcare and family planning that prevents excessive maternal and newborn morbidity and mortality.

Provide basic obstetric and neonatal emergency services in health centres; Trained midwives and supplies for normal births and basic obstetric and neonatal emergency management; Trained medical personnel; Supplies; Clean delivery kits and essential newborn kits to pregnant women; and Birth Attendants for essential newborn care when access to a health centre is not possible.

Five maternal health and newborn care facilities for 500,000 inhabitants are in place and operating 24 hours a day, seven days a week.

Sexual and reproductive health standard 2.3.3: HIV: People have access to healthcare that prevents transmission and reduces morbidity and mortality due to HIV.

Implement minimum activities to prevent HIV/AIDS, both in health care settings and among the general population; and ensure continued antiretroviral treatment.

Sexual and reproductive health standard 2.3.2: Sexual violence and clinical management of rape: People have access to healthcare that is safe and responds to the needs of survivors of sexual violence.

Implement measures to reduce the risk of sexual violence, in coordination with other relevant sectors or groups.

Ensure services for appropriate clinical management of sexual violence, including HIV/AIDS prophylaxis and access to mental health and psychosocial support and legal assistance.

Inform, educate and communicate the importance of seeking medical attention within 72 hours of sexual violence.

All health centres have a trained local health professional available 24 hours a day; sufficient supplies and equipment for the clinical management of rape survivors' services, based on national or World Health Organization (WHO) protocols.

5. CARE OF INJURIES

Injuries and trauma can be a cause of high mortality and morbidity in many emergencies.

In a sudden emergency, like an earthquake, there may be a high number of injuries resulting in a mass casualty incident.

Complex emergencies and armed conflicts can also cause specific trauma from weapons and war. Therefore, it is important for health actors to understand mass casualty management, triage and basic emergency care.

Injury and trauma care standard 2.4: People have access to safe and effective trauma care during crises to prevent avoidable mortality, morbidity, suffering and disability.

Establish or strengthen an appropriate standardised triage system, including guidance on: assessment, prioritisation, basic resuscitation and criteria for emergency referral.

Health centres and clinics have access to at least four contraceptive methods (pills, injectables, IUDs, implants) between three and six months after the onset of the crisis.

Ensure standard assistive devices and mobility aids (for example, wheelchairs and crutches) are available to injured patients and people with disabilities.

6. MENTAL HEALTH

Mental health and psychosocial problems occur in all humanitarian settings. The horrors, losses, uncertainties and other stressors associated with conflict, displacement and crisis put people at greater risk of social, behavioural, psychological and psychiatric problems. Mental health and psychosocial support involve multisectoral actions.

Mental health standard 2.5: People of all ages have access to healthcare that addresses mental health conditions and associated impaired functioning.

Ensure the availability of trained personnel and basic clinical mental healthcare for priority conditions in each health facility.

Provide psychological interventions for people with long term mental health problems which cause distress; and to minimise alcohol- and drug-related harm.

7. NON-COMMUNICABLE DISEASES

Protracted crises, together with an ageing population, have led to increased non-communicable diseases in humanitarian contexts.

While populations vary widely, at the global level in any adult population of 10,000 people, there are likely to be between 1,500 and 3,000 people with hypertension; between 500 and 2,000 people with diabetes and between 3 and 8 acute heart attacks over a normal 90-day period.

Non-communicable diseases standard 2.6: Care of non-communicable diseases: People have access to preventive programmes, diagnostics and essential therapies for acute complications and long-term management of non-communicable diseases.

Implement programmes, using a step-by-step approach based on the priorities of saving lives and alleviating suffering.

Primary health care centres use standard operating procedures for the referral of Non-communicable diseases (NCD) patients to specialised care centres.

8. RELIEF OF SUFFERING AND CARE AT THE END OF LIFE

End-of-life care can be key to alleviating human suffering after a disaster or conflict.

Prevention and relief of acute pain, including intra- and post-operative pain, for example, can help reduce distress, morbidity and mortality.

There is also a need to provide adequate care for people who are expected to die.

Palliative care standard 2.7: People have access to palliative and end-of-life care that relieves pain and suffering, maximises the comfort, dignity and quality of life of patients, and provides support for family members.

Establish guidelines and policies on end-of-life care.

Allow dying patients to receive palliative care, in health centres, hospitals, mobile clinics and field hospitals, with essential palliative drugs available at all times.

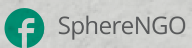
Further reading:
To find out more about Sphere:
www.spherestandards.org

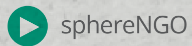
To access online versions of the Sphere Handook and other Humanitarian Standards Partnership handbooks:
www.hspstandards.org

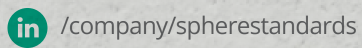
ABBREVIATIONS AND ACRONYMS

- **CHS Core Humanitarian Standard on Quality and Accountability**
- **CPMS Child Protection Minimum Standards**
- **DPT diphtheria, pertussis and tetanus**
- **EPI Expanded Programme on Immunization**
- **GBV gender-based violence**
- **IASC Inter-agency standing committee**
- **IHL international humanitarian law**
- **INEE Inter-Agency Network for Education in Emergencies**
- **LEGS Livestock Emergency Guidelines and Standards**
- **MEAL monitoring, evaluation, accountability and learning**
- **MERS Minimum Economic Recovery Standards**
- **NCDs non-communicable diseases**
- **NGO non-governmental organization**
- **OCHA United Nations Office for the Coordination of Humanitarian Affairs**
- **SEEP Small Enterprise Education and Promotion (Network)**
- **UN United Nations**
- **WASH water supply, sanitation and hygiene promotion**

spherestandards.org


SphereNGO


sphereNGO


/company/spherestandards